

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6605

CERTIFICATE OF DEATH

06593

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3 y 5 m 18 d	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Md.		d. STREET ADDRESS 6717 Eastern Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Leo Last Abell		4. DATE OF DEATH Month 6 Day 2 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-14-77 (77)
9. AGE (In years birth day) yrs. 81		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME French Abell		14. MOTHER'S MAIDEN NAME Hannah	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Springfield Hospital Records & wife	
17. INFORMANT Springfield Hospital Records & wife		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with Cor. Arterioscler. with psych. reaction Fracture of left hip		INTERVAL BETWEEN ONSET AND DEATH days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Pt. fell down on the ward on 5-27-59		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ward		20f. (City or town) (County) (State) Sykesville, Carroll, Maryland	
21. I certify that I attended the deceased from 12-14- , 19 55 , to 6-2- , 19 59 , that I last saw the deceased alive on 6-2- , 19 59 , and that death occurred at 3:40 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund Lusthaus		DATE SIGNED 6-2-59	
PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.		Sykesville, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/5-1959	22c. NAME OF CEMETERY OR CREMATORY Seabury Hill	22d. LOCATION (City, town, or county) (State) Seabury Hill Md
23. FUNERAL DIRECTOR'S SIGNATURE R.G. Mattingly		24a. REC'D BY REGISTRAR DATE JUN 4 59	
ADDRESS 131-11th St. S.S.		24b. REGISTRAR'S SIGNATURE Arthur S. Krous	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

6605

1966

NAME OF DECEASED GARY, GARY		DATE OF BIRTH 3-2-1935		PLACE OF BIRTH BALTIMORE, MARYLAND	
SEX Male		RACE White		EDUCATION High School	
MARRIAGE Married		DATE OF MARRIAGE 10-1-58		NAME OF SPOUSE GARY, GARY	
OCCUPATION Teacher		DATE OF DEATH 10-1-66		PLACE OF DEATH BALTIMORE, MARYLAND	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		CERTIFICATE NO. 6605	
SIGNATURE OF PHYSICIAN J. H. HARRIS		DATE 10-1-66		PLACE BALTIMORE, MARYLAND	
SIGNATURE OF REGISTRAR J. H. HARRIS		DATE 10-1-66		PLACE BALTIMORE, MARYLAND	

6606

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 36 years 27 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 433 W 24th Street	
3. NAME OF DECEASED (Type or print) First John Middle Wesley Last Ament		4. DATE OF DEATH Month 6 Day 28 Year 19 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-21-88
9. AGE (In years last birthday) yrs. 71		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Ament		14. MOTHER'S MAIDEN NAME Maggie Bornman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unkn	
INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Passive Congestion of lungs 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH days years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epileptic psychosis, Transcervical fracture of left femur			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10-20- , 19 54 , to 6-27- , 19 59 , that I lost saw the deceased alive on 6-27- , 19 59 , and that death occurred at 0:20 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital 6-28-59			
ACTUAL SIGNATURE Edmund Lusthaus M.D.		PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-1-59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		24a. REC'D BY REGISTRAR JUN 30 '59	
ADDRESS 5305 Harford Rd.		24b. REGISTRAR'S SIGNATURE Arthur J. Thane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

525240

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6607 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06595

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville	c. LENGTH OF STAY in 1b 1yr. 5mos. 8days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. STREET ADDRESS 1428 E. Baltimore Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Dorothy Middle Laverne Last Bellamy		4. DATE OF DEATH Month June Day 15 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 15, 1910
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 49 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesclerk		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Aspinall		14. MOTHER'S MAIDEN NAME Mary Kergon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute peritonitis 540.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Perforated chronic gastric ulcer DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type.			INTERVAL BETWEEN ONSET AND DEATH Days Months
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None.	
20c. TIME OF INJURY Month, Day, Year Hour 0 a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James T. Marsh		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/19/59	
22c. NAME OF CEMETERY OR CREMATORY Frostburg Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Luther H. Haight		ADDRESS Sykesville, Md.	
24a. REC'D BY REGISTRAR JUN 23 '59		24b. REGISTRAR'S SIGNATURE Crispin S. Hanes	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

6608

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>561 Old Baltimore Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARRIE EASTER BLIZZARD</u>				4. DATE OF DEATH Month Day Year <u>JUNE 27 19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 8, 1910</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Carroll Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harvey Lambert</u>				14. MOTHER'S MAIDEN NAME <u>Debbie Wanta</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Mr James Blizzard Westminster Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Cervix & metastasis</u> <u>171X</u> DUE TO <u>to Liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anemia & Cachexia</u> DUE TO (c) <u>6 mo</u>						INTERVAL BETWEEN ONSET AND DEATH <u>about 2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April</u> , 19 <u>58</u> , to <u>June 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 27</u> , 19 <u>59</u> , and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Glenn Speicher</u> M.D.				ADDRESS (Street, city or town, state) <u>Westminster Md</u> DATE SIGNED <u>6/29/59</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Wed July 1 59</u>		<u>Kraders Cemetery</u>		<u>Rural Westminster Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. S. Myers, Jr.</u> ADDRESS <u>Westminster Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Ref. No. 10

<p>1. NAME OF DECEASED</p> <p><i>JOHN J. SMITH</i></p>		<p>2. SEX</p> <p><i>Male</i></p>		<p>3. AGE</p> <p><i>45</i></p>	
<p>4. DATE OF DEATH</p> <p><i>10/15/1910</i></p>		<p>5. TIME OF DEATH</p> <p><i>10:30 AM</i></p>		<p>6. PLACE OF DEATH</p> <p><i>Home</i></p>	
<p>7. CAUSE OF DEATH</p> <p><i>Heart Disease</i></p>		<p>8. DISEASE OR INJURY</p> <p><i>Myocardial Infarction</i></p>		<p>9. MANNER OF DEATH</p> <p><i>Natural</i></p>	
<p>10. SIGNATURE OF PHYSICIAN</p> <p><i>Dr. J. H. Jones</i></p>		<p>11. SIGNATURE OF REGISTRAR</p> <p><i>W. H. Smith</i></p>		<p>12. SIGNATURE OF WITNESSES</p> <p><i>John J. Smith, Jr., Mary J. Smith</i></p>	
<p>13. PLACE OF BIRTH</p> <p><i>London, England</i></p>		<p>14. DATE OF BIRTH</p> <p><i>10/15/1865</i></p>		<p>15. PLACE OF DEATH</p> <p><i>Home</i></p>	
<p>16. OCCUPATION</p> <p><i>Engineer</i></p>		<p>17. MARITAL STATUS</p> <p><i>Married</i></p>		<p>18. EDUCATION</p> <p><i>High School</i></p>	
<p>19. RELIGION</p> <p><i>Anglican</i></p>		<p>20. RACE</p> <p><i>White</i></p>		<p>21. COLOR</p> <p><i>White</i></p>	
<p>22. SIGNATURE OF DECEASED</p> <p><i>John J. Smith</i></p>		<p>23. SIGNATURE OF PHYSICIAN</p> <p><i>Dr. J. H. Jones</i></p>		<p>24. SIGNATURE OF REGISTRAR</p> <p><i>W. H. Smith</i></p>	
<p>25. SIGNATURE OF WITNESSES</p> <p><i>John J. Smith, Jr., Mary J. Smith</i></p>		<p>26. SIGNATURE OF DECEASED</p> <p><i>John J. Smith</i></p>		<p>27. SIGNATURE OF PHYSICIAN</p> <p><i>Dr. J. H. Jones</i></p>	
<p>28. SIGNATURE OF REGISTRAR</p> <p><i>W. H. Smith</i></p>		<p>29. SIGNATURE OF WITNESSES</p> <p><i>John J. Smith, Jr., Mary J. Smith</i></p>		<p>30. SIGNATURE OF DECEASED</p> <p><i>John J. Smith</i></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06597

6609

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. LENGTH OF STAY IN 1b <u>1 hour</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>E. Main St.</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HERBERT</u> Middle <u>L.</u> Last <u>BOLLINGER</u>				4. DATE OF DEATH <u>June 10 1959</u> Month <u>June</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 8 1899</u> yrs. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elmer Bollinger</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wantz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>210-14-7897</u>		17. INFORMANT <u>Mrs. Herbert L. Bollinger</u>		Address <u>Hampstead Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Card. Vasc. Disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 Months</u> <u>5 years</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>November</u> , 19 <u>58</u> , to <u>6/10/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/9/59</u> , 19 <u>59</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M.C. Porterfield</u>				ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u>		DATE SIGNED <u>6/10/59</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield, M.D.</u>				Hampstead, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 13, 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadow Branch</u>		22d. LOCATION (City, town, or county) <u>Rural Westminster, Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. E. Myers, Jr.</u>				ADDRESS <u>Westminster, Md.</u>		24a. REC'D BY REGISTRAR <u>June 15 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

THE UNIVERSITY OF CHICAGO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6610

CERTIFICATE OF DEATH

Reg. Dist. No. 06598

1. PLACE OF DEATH o. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Lineboro</i>	c. LENGTH OF STAY IN TB <i>25 yrs</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Lineboro MD PD #1</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Lineboro, Md. PD #1</i>		d. STREET ADDRESS <i>Lineboro, Md. PD #1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>MILES ALVIN BORTNER</i>		4. DATE OF DEATH Month <i>June</i> Day <i>10</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 21 1896</i>
9. AGE (In years lost birthday) <i>62</i> yrs.		10. IF UNDER 1 YEAR: Months <i>6</i> Days <i>10</i> Hours <i>10</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Track Hand</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>M. M. R. Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>York Co. Pa</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William H. Bortner</i>		14. MOTHER'S MAIDEN NAME <i>Theresea Quable</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>705-10-5824</i>	
17. INFORMANT <i>Mr. Miles Bortner</i>		Address <i>Lineboro, Md. PD #1</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Arteriosclerosis</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>4 mo</i> <i>2 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>March</i> , 19 <i>59</i> , to <i>June 10</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>6/9</i> , 19 <i>59</i> , and that death occurred at <i>9:10 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>28 South Main Hampstead, Md.</i> DATE SIGNED <i>6/12/59</i>			
ACTUAL SIGNATURE <i>M. C. Porterfield</i>		M.D. <i>6/12/59</i>	
PHYSICIAN'S NAME (Type) <i>M. C. Porterfield</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>June 13 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Lineboro Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Lineboro, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. C. Porterfield</i>		ADDRESS <i>28 South Main</i>	24. REC'D BY REGISTRAR <i>June 15 '59</i>
		24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6818

100508

PLACE OF DEATH HOME		MARRIAGE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
DATE OF DEATH JAN 10 1968		TIME OF DEATH 10:00 AM	
PLACE OF BIRTH BALTIMORE, MD		DATE OF BIRTH JAN 10 1968	
SEX FEMALE		RACE WHITE	
OCCUPATION HOUSEWIFE		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		MEDICAL HISTORY HYPERTENSION	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESS (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)	

1

100508-100509-100510-100511-100512-100513-100514-100515-100516-100517-100518-100519-100520-100521-100522-100523-100524-100525-100526-100527-100528-100529-100530-100531-100532-100533-100534-100535-100536-100537-100538-100539-100540-100541-100542-100543-100544-100545-100546-100547-100548-100549-100550-100551-100552-100553-100554-100555-100556-100557-100558-100559-100560-100561-100562-100563-100564-100565-100566-100567-100568-100569-100570-100571-100572-100573-100574-100575-100576-100577-100578-100579-100580-100581-100582-100583-100584-100585-100586-100587-100588-100589-100590-100591-100592-100593-100594-100595-100596-100597-100598-100599-100600-100601-100602-100603-100604-100605-100606-100607-100608-100609-100610-100611-100612-100613-100614-100615-100616-100617-100618-100619-100620-100621-100622-100623-100624-100625-100626-100627-100628-100629-100630-100631-100632-100633-100634-100635-100636-100637-100638-100639-100640-100641-100642-100643-100644-100645-100646-100647-100648-100649-100650-100651-100652-100653-100654-100655-100656-100657-100658-100659-100660-100661-100662-100663-100664-100665-100666-100667-100668-100669-100670-100671-100672-100673-100674-100675-100676-100677-100678-100679-100680-100681-100682-100683-100684-100685-100686-100687-100688-100689-100690-100691-100692-100693-100694-100695-100696-100697-100698-100699-100700-100701-100702-100703-100704-100705-100706-100707-100708-100709-100710-100711-100712-100713-100714-100715-100716-100717-100718-100719-100720-100721-100722-100723-100724-100725-100726-100727-100728-100729-100730-100731-100732-100733-100734-100735-100736-100737-100738-100739-100740-100741-100742-100743-100744-100745-100746-100747-100748-100749-100750-100751-100752-100753-100754-100755-100756-100757-100758-100759-100760-100761-100762-100763-100764-100765-100766-100767-100768-100769-100770-100771-100772-100773-100774-100775-100776-100777-100778-100779-100780-100781-100782-100783-100784-100785-100786-100787-100788-100789-100790-100791-100792-100793-100794-100795-100796-100797-100798-100799-100800-100801-100802-100803-100804-100805-100806-100807-100808-100809-100810-100811-100812-100813-100814-100815-100816-100817-100818-100819-100820-100821-100822-100823-100824-100825-100826-100827-100828-100829-100830-100831-100832-100833-100834-100835-100836-100837-100838-100839-100840-100841-100842-100843-100844-100845-100846-100847-100848-100849-100850-100851-100852-100853-100854-100855-100856-100857-100858-100859-100860-100861-100862-100863-100864-100865-100866-100867-100868-100869-100870-100871-100872-100873-100874-100875-100876-100877-100878-100879-100880-100881-100882-100883-100884-100885-100886-100887-100888-100889-100890-100891-100892-100893-100894-100895-100896-100897-100898-100899-100900-100901-100902-100903-100904-100905-100906-100907-100908-100909-100910-100911-100912-100913-100914-100915-100916-100917-100918-100919-100920-100921-100922-100923-100924-100925-100926-100927-100928-100929-100930-100931-100932-100933-100934-100935-100936-100937-100938-100939-100940-100941-100942-100943-100944-100945-100946-100947-100948-100949-100950-100951-100952-100953-100954-100955-100956-100957-100958-100959-100960-100961-100962-100963-100964-100965-100966-100967-100968-100969-100970-100971-100972-100973-100974-100975-100976-100977-100978-100979-100980-100981-100982-100983-100984-100985-100986-100987-100988-100989-100990-100991-100992-100993-100994-100995-100996-100997-100998-100999-101000

6613

CERTIFICATE OF DEATH

06601

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Pennsylvania</i> b. COUNTY <i>York</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>7 years</i> <i>7 Hanover</i> <i>75X-3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Longview Nursing Home</i>		d. STREET ADDRESS <i>572 Broadway</i>	
3. NAME OF DECEASED (Type or print) First <i>Virginia</i> Middle <i>L.</i> Last <i>Bowman</i>		4. DATE OF DEATH Month <i>June</i> Day <i>5</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 30, 1870</i> 88 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Emmanuel Bush</i>		14. MOTHER'S MAIDEN NAME <i>Caroline Bush</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Eggs & W. Mockley</i>		Address <i>Hanover Pa</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocarditis</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Cardio Vascular Disease</i> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 1959		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <i>Aug 9</i> , 1957 to <i>June 5</i> , 1959, that I last saw the deceased alive on <i>June 5</i> , 1959, and that death occurred at <i>11 A</i> . M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Joseph E. Bush</i> M.D.		ADDRESS (Street, city or town, state) <i>Hampstead Md 6/5/59</i> DATE SIGNED <i>6/5/59</i>	
PHYSICIAN'S NAME (Type) <i>Joseph E. Bush MD</i>		<i>HAMPSTEAD MD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried 6/8/59</i>		22b. DATE WHEREOF <i>York Road</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Frederick Berkeham</i>		22d. LOCATION (City, town, or county) (State) <i>Hanover Pa RD York Co</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frederick Berkeham</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Hume</i>	
ADDRESS _____		24b. REGISTRAR'S SIGNATURE _____	
DATE <i>JUN 8 '59</i>		_____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06599

6611

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 3819 Bayonne Avenue	
3. NAME OF DECEASED (Type or print) First Wilhelmina Middle Last Breyer		4. DATE OF DEATH Month June Day 26 , Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 11, 1881
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Breyer		14. MOTHER'S MAIDEN NAME Ernestine Schlagle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-05-4475	
INFORMANT Springfield State Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic degenerative myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Months Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with senile brain disease, with psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 18, 1958 , to June 26, 1959 , that I last saw the deceased alive on June 26, 1959 , and that death occurred at 12:30 p.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Konstantin Weber M.D.		ADDRESS (Street, city or town, state) Oak Street DATE SIGNED 6/26/59	
PHYSICIAN'S NAME (Type) Konstantin Weber, M. D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/29/59	22c. NAME OF CEMETERY OR CREMATORY Western	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stansbury		ADDRESS 6411 Windsor Mill Rd	
24a. REC'D BY REGISTRAR DATE JUL 1 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

1911

Age

Sex

Color

Married

Single

Widow

Place of Birth

Place of Death

Occupation

Cause of Death

Time

Date

Time

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Physician's Certificate

Physician's Certificate

Physician's Certificate

Physician's Certificate

Physician's Certificate

Physician's Certificate

Physician's Certificate

Physician's Certificate

Physician's Certificate

6614

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton c. LENGTH OF STAY IN lb 596 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Grasonville d. STREET ADDRESS Kent Narrows e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Edward Last Brinkley				4. DATE OF DEATH Month June Day 12 Year 1959			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-1-1878	
9. AGE (In years last birthday) yrs. 81		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Centerhill, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oyster Shucker				10b. KIND OF BUSINESS OR INDUSTRY Oyster		11. BIRTHPLACE (State or foreign country) Centerhill, N. C.	
13. FATHER'S NAME Richard Brinkley				14. MOTHER'S MAIDEN NAME Margaret Edner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 222-01-5099		INFORMANT James Edward Brinkley - Patient		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency 002 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Far advanced pulmonary tuberculosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 24, 1957 to June 12, 1959 , that I last saw the deceased alive on June 12, 1959 , and that death occurred at 4:10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edgars M. Maculans		M.D.		ADDRESS (Street, city or town, state) Henryton, Maryland		DATE SIGNED 6-12-59	
PHYSICIAN'S NAME (Type) Dr. Edgars M. Maculans, Supt.		HENRYTON STATE HOSPITAL, HENRYTON, MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/16/59		22c. NAME OF CEMETERY OR CREMATORY Grasonville Cem.		22d. LOCATION (City, town, or county) (State) Grasonville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James H. Vachell				ADDRESS Porton, Md.		24a. REC'D BY REGISTRAR DATE JUN 18 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4. *Effect of the number of trials*

2005

Environ Biol Fish (2015) 98:219–22

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

6612 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 2 mo. 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS 5082 E. Federal Street	
3. NAME OF DECEASED (Type or print) First Ella Middle May Last Brown		4. DATE OF DEATH Month June Day 16 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1878
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Heck		14. MOTHER'S MAIDEN NAME Amelia Kline	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -	
INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Generalized lymphosarcomatosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 2 , 19 59 , to June 16 , 19 59 , that I last saw the deceased alive on June 15 , 19 59 , and that death occurred at 6:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital 6/16/59			
ACTUAL SIGNATURE Agustin del Campo		M.D. Springfield State Hospital	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-19-59	
22c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John C. Miller Inc.		24a. REC'D BY REGISTRAR DATE JUN 19 '59	
ADDRESS - 2431-35 E. Olive Street		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

152243

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2000

Department of Psychology, University of Illinois at Chicago, Chicago, IL 60607

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C. A. J. Oudejans, D. van der Helm

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6601

CERTIFICATE OF DEATH

06603

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CARROLL Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 WESTMINSTER MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>1218 1/2 MAIN ST</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES HENRY CAMPBELL</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>1</u> Year <u>19 59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 19 1877</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUTCHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN CAMPBELL</u>		14. MOTHER'S MAIDEN NAME <u>RACHAEL FLICKENER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>220-07-1352</u>	
17. INFORMANT <u>Johnson - 218 1/2 MAIN ST. WESTMINSTER</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis senilis</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 15, 1949</u> , to <u>June 15, 1959</u> , that I last saw the deceased alive on <u>June 30, 1959</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Westminster Md.</u> DATE SIGNED <u>6-1-59</u>			
ACTUAL SIGNATURE <u>C. H. Billingslea</u> M.D.		DATE SIGNED <u>6-1-59</u>	
PHYSICIAN'S NAME (Type) <u>C. H. Billingslea</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/4/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	22d. LOCATION (City, town, or county) (State) <u>FINKSBERG MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Saffell Jr.</u> ADDRESS <u>254 E. MAIN ST. WESTMINSTER, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 2 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. After the certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. After the certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office.

Dr. Billingslea 15 East St. 0 124 with

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15M 9/55

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 51y, 8mo, 21days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS 5806 Harford Road							
3. NAME OF DECEASED (Type or print) First Raymond Middle Campeggi Last Campeggi				4. DATE OF DEATH Month June Day 3 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-17-1893	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank Campeggi		14. MOTHER'S MAIDEN NAME Elizabeth Otis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of the stomach DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 151X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental deficiency without psychosis.							INTERVAL BETWEEN ONSET AND DEATH Months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 11 , 19 37 , to June 3 , 19 59 , that I last saw the deceased alive on June 3 , 19 59 , and that death occurred at 11:15PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 6/4/59							
ACTUAL SIGNATURE Ellis J. Margolin		M.D. Springfield State Hospital		PHYSICIAN'S NAME (Type) Ellis Margolin, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-8-59		22c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				ADDRESS 5305 Harford Rd.		24a. RECEIVED BY REGISTRAR JUN 8 1959	
						24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1915

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED		SEX		AGE	
John Doe		Male		45	
DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
Jan 1, 1870		New York City		Teacher	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
Jan 15, 1915		Baltimore, Md.		Heart Disease	
TIME OF DEATH		MANNER OF DEATH		MEDICAL ATTENDANT	
10:00 AM		Natural		Dr. J. Smith	
SIGNATURE OF DECEASED		SIGNATURE OF MEDICAL ATTENDANT		SIGNATURE OF REGISTRAR	
John Doe		Dr. J. Smith		[Signature]	

NAME OF DECEASED		SEX		AGE	
John Doe		Male		45	
DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
Jan 1, 1870		New York City		Teacher	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
Jan 15, 1915		Baltimore, Md.		Heart Disease	
TIME OF DEATH		MANNER OF DEATH		MEDICAL ATTENDANT	
10:00 AM		Natural		Dr. J. Smith	
SIGNATURE OF DECEASED		SIGNATURE OF MEDICAL ATTENDANT		SIGNATURE OF REGISTRAR	
John Doe		Dr. J. Smith		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for file as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06605

6616

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster, R.D.1 (Silver Run)				d. STREET ADDRESS Westminster, R.D.1 (Silver Run)			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Clarence Edward Casman				4. DATE OF DEATH Month Day Year 6/4/59 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/16/1901		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Cutter			10b. KIND OF BUSINESS OR INDUSTRY Shoe Factory		11. BIRTHPLACE (State or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Mervin Cashman				14. MOTHER'S MAIDEN NAME Bessie Clingan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-05-1267		17. INFORMANT Address Mrs. Lillie Cashman, Westminster, Md. R.D.1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY THROMBOSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 30 MIN. 10 WEEKS							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 26 , 19 59 , to June 4 , 19 59 , that I last saw the deceased alive on June 4 , 19 59 , and that death occurred at 6:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED L. L. Potter M.D. 12 W. King St. Littlestown, Pa 6-5-59 ACTUAL SIGNATURE L. L. POTTER M.D. 12 W. KING ST. LITTLESTOWN, PA PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/7/59		22c. NAME OF CEMETERY OR CREMATORY Kriders Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Westminster, Carroll Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little				ADDRESS Littlestown, Pa.		24a. REC'D BY REGISTRAR DATE JUN 8 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

6617

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>Huffman Mill Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Huffman Mill Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lola Elith Baumer</u>		4. DATE OF DEATH <u>June 25 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 14 1888</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Baumer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-05-8118</u>	
17. INFORMANT <u>Luella Ruff</u>		Address <u>Hampstead Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>suddenly</u> <u>6 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u>59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Sept 4</u> 19 <u>53</u> , to <u>June 25</u> 19 <u>59</u> , that I last saw the deceased alive on <u>June 23</u> 19 <u>59</u> , and that death occurred at <u>9A</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>6/25/59</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D.</u>		<u>HAMPSTEAD MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-25-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Shiloh</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E Gipton</u> ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>June 30 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

00300

<p>NAME OF DECEASED <i>John Doe</i></p>		<p>DATE OF DEATH <i>Jan 15 1900</i></p>	
<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>	
<p>PLACE OF BIRTH <i>Johns Hopkins</i></p>		<p>DATE OF BIRTH <i>Jan 1 1855</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>PLACE OF DEATH <i>Johns Hopkins</i></p>	
<p>DATE OF INTERMENT <i>Jan 17 1900</i></p>		<p>PLACE OF INTERMENT <i>Johns Hopkins</i></p>	
<p>SIGNATURE OF PHYSICIAN <i>John Doe</i></p>		<p>SIGNATURE OF REGISTRAR <i>John Doe</i></p>	

OUT OF DATE V
RECEIVED
JAN 15 1900
BALTIMORE, MD

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RECEIVED
JAN 15 1900
BALTIMORE, MD

Page 4
VS A15 (4)
ISM 9/58

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06607

6618

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 7mos.5days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Cleary Last Dowdy		4. DATE OF DEATH Month June Day 29, Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 18, 1893
9. AGE (In years last birthday) yrs. 65		10. IF UNDER 1 YEAR Months Days Hours Min. 65	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Cleary		14. MOTHER'S MAIDEN NAME Mary Cosgrow	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -	
INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Branchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under-lying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction. Carcinoma of the cervix.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 24, 1958 to June 29, 1959 , that I last saw the deceased alive on June 29, 1959 , and that death occurred at 8:55P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund Lusthaus M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		DATE SIGNED 6/30/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/3/59	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Balto MD	
23. FUNERAL DIRECTOR'S SIGNATURE Edmond J. Luck		24a. REC'D BY REGISTRAR JUL 1 '59	
ADDRESS 5305 Bayford		24b. REGISTRAR'S SIGNATURE Arthur J. Frank	

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Edmund Spenser: *Edmund Spenser*

• • • continued from page 10 • • •

6619

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 3 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pullen Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle F. Last EVANS, SR.		4. DATE OF DEATH Month JUNE Day 2, Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-30-1891
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired merchant		10b. KIND OF BUSINESS OR INDUSTRY hardware	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Richard Evans		14. MOTHER'S MAIDEN NAME Rhoda C. Colson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Address Mrs. Jessie M. Evans, same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis, Cerebral thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) rd. hypertension, arteriosclerosis, DUE TO (c) Colostomy - anemia.			INTERVAL BETWEEN ONSET AND DEATH 1957 to 2 June 59
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1957 to 2 June 1959 , that I last saw the deceased alive on 2 June 1959 , and that death occurred at 7:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Howard E. Hall M.D.		ADDRESS (Street, city or town, state) Sparrow, Md DATE SIGNED 2 June 59	
PHYSICIAN'S NAME (Type) HOWARD E. HALL			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6-5-1959	22c. NAME OF CEMETERY OR CREMATORY Morgan Chapel	22d. LOCATION (City, town, or county) (State) Carroll Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR DATE JUN 5 '59	24b. REGISTRAR'S SIGNATURE Arthur E. Hanks

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

STATEMENT OF DEATH

CHIEF

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6620

CERTIFICATE OF DEATH

06609

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 29 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 2706 Halcyon Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carolyn Middle Fredericka Last Farris				4. DATE OF DEATH Month June Day 11 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 26, 1911	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office work				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Ortel				14. MOTHER'S MAIDEN NAME Evel Ertel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 212-10-3098		17. INFORMANT Springfield Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic brain cancer 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of the breast DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH months years.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychotic depressive reaction.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 12 , 19 59 , to June 11 , 19 59 , that I last saw the deceased alive on June 11 , 19 59 , and that death occurred at 5:05 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 6/12/59							
ACTUAL SIGNATURE Agustin del Campo				PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6-15-1959		22c. NAME OF CEMETERY OR CREMATORY St. Michael's Luth.		22d. LOCATION (City, town, or county) (State) Perry Hall Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home				ADDRESS 7401 Belair Road		24a. REC'D BY REGISTRAR DATE JUN 15 '59	
						24b. REGISTRAR'S SIGNATURE Clifford P. Kenna	

0032-49

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

6621

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06610

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville	c. LENGTH OF STAY IN 1b 3 mos. 10 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 1221 Valley Street	
3. NAME OF DECEASED (Type or print) First Marie Middle Helena Last Flading		4. DATE OF DEATH Month June Day 23 , Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1924
9. AGE (In years last birthday) 34 yrs.		IF UNDER 1 YEAR Months 3 Days 10	IF UNDER 24 HRS. Hours 10 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Work		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Albert Flading	
14. MOTHER'S MAIDEN NAME Sarah Geary		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute peritonitis DUE TO (b) Perforated gastric ulcer DUE TO (c) Foreign body		INTERVAL BETWEEN ONSET AND DEATH Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, paranoid type.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 4 or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James T. Marsh		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6/24/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 27/59	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Philip Herwig, Sons		24a. REC'D BY REGISTRAR 2024 JUN 29 59	
ADDRESS 2024		24b. REGISTRAR'S SIGNATURE Arthur L. Huns	

FOR STATE
HEALTH DEPT.

1

010110

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0052

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/58

1
6622
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

06611

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS Dubbs Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frances Middle Foote Last Goeller		4. DATE OF DEATH Month June Day 30, Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 9, 1872
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin F. Foote		14. MOTHER'S MAIDEN NAME Ellen McKay	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 31, 1959 , to June 30, 1959 , that I last saw the deceased alive on June 30, 1959 , and that death occurred at 10:05A , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund Lusthaus		ADDRESS (Street, city or town, state) Springfield State Hospital	
DATE SIGNED 6/30/59			
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.		Sykesville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-3-59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Methodist		22d. LOCATION (City, town, or county) (State) Parkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.		24a. REC'D BY REGISTRAR DATE JUL 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

STATE OF NEW YORK

11000

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IN SENATE
January 1, 1902
REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1901
ALBANY:
JAMES BRONKHORST, JR.,
STATE PRINTER, 1902.

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6623

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Westminster		c. LENGTH OF STAY IN lb life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Westminster	
		f. STREET ADDRESS R.D. 5	
3. NAME OF DECEASED (Type or print) First FANNIE Middle B. Last HAINES		4. DATE OF DEATH Month JUNE Day 12 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-17-1869
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Frederick Wagner		14. MOTHER'S MAIDEN NAME Mary Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Stanley L. Haines,		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Valvular heart disease DUE TO (c) 2 days 3 yrs		INTERVAL BETWEEN ONSET AND DEATH 2 days 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral softening		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 10c)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1 , 19 49 to June 12 , 19 59 that I last saw the deceased alive on June 11 , 19 59 , and that death occurred at 15 Kemper Ave , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Westminster Md			
ACTUAL SIGNATURE E. REESE WILKENS		DATE SIGNED 6/13/59	
PHYSICIAN'S NAME (Type) E. REESE WILKENS			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-15-1959	
22c. NAME OF CEMETERY OR CREMATORY Sams Creek Brethren		22d. LOCATION (City, town, or county) (State) Carroll Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.	
24a. REC'D BY REGISTRAR JUN 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1923

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that the deceased
was the father of
one the deceased
born on 1st of May 1923
at 1215 1/2 Street
New York City

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6624

CERTIFICATE OF DEATH

06613

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROLAND RUSSELL HILL</u>		4. DATE OF DEATH Month Day Year <u>JUNE 23 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/21/1895</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MOTOR TENDER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ANDREW HILL</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA WILLIAMS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-03-1008</u>	
17. INFORMANT <u>MRS. HATTIE T. HILL</u>		Address <u>NEW WINDSOR MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Myeloma</u> 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb</u> 19 <u>59</u> , to <u>June 23</u> 19 <u>59</u> , that I last saw the deceased alive on <u>June 22</u> 19 <u>59</u> , and that death occurred at <u>9:00 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James J. Marsh</u>		DATE SIGNED <u>6/25/59</u>	
PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>		ADDRESS (Street, city or town, state) <u>Washington</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/29/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE CEM. FREDERICK COUNTY MD</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartley</u>		24a. REC'D BY REGISTRAR <u>Charing S. Kraus</u>	
ADDRESS <u>New Windsor MD</u>		DATE <u>JUN 29 '59</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06614

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>3Y01-4</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henryton</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> ✓		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Henryton State Hospital</u>			d. STREET ADDRESS <u>2239 Druid Hill Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>P.</u> Last <u>Hines</u>			4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>19 59</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>? ? 1907</u>		9. AGE (In years last birthday) <u>51</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>John P. Hines ?</u>			14. MOTHER'S MAIDEN NAME <u>Nettie Hines ?</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		INFORMANT <u>John P. Hines - Patient</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular insufficiency</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastasis of tumor in brain and lungs</u> DUE TO (c) <u>Tumor in liver - possibly carcinoma</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 11</u> , 19 <u>59</u> , to <u>June 13</u> , 19 <u>59</u> that I last saw the deceased alive on <u>June 13</u> , 19 <u>59</u> , and that death occurred at <u>1:00A</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Henryton, Maryland</u> DATE SIGNED <u>6-13-59</u>					
ACTUAL SIGNATURE <u>Edgars M. Maculans</u>		M.D. <u>Henryton, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Edgars M. Maculans, Supt.</u>		<u>Henryton State Hospital, Henryton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-17-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>mt Calvary Cem</u>	
22d. LOCATION (City, town, or county) (State) <u>Henryton, Md</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas O. Wilson - Secretary</u>		ADDRESS <u>1600</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 19 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

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1990-1991

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 11mos.2days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Catherine Middle Easter Last Murphy Hippler		4. DATE OF DEATH Month June Day 25 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 3, 1884
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jerome Murphy		14. MOTHER'S MAIDEN NAME Mary O'Neil	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-24-1445A	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction. Late latent syphilis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 23, 1958 , to June 25, 1959 , that I last saw the deceased alive on June 25, 1959 , and that death occurred at 9:30P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Agustin del Campo</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital 6/26/59	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland	
22a. (BURIAL, CREMATION, REMOVAL) (Specify) 6/30/59		22b. DATE THEREOF 6/30/59	
22c. NAME OF CEMETERY OR CREMATORY Barkwood		22d. LOCATION (City, town, or county) (State) Bald Md	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lemond J. Kunk</i>		24a. REC'D BY REGISTRAR DATE JUN 29 '59	
ADDRESS 5305 Harford		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6602 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. LENGTH OF STAY IN 1b <u>52 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>45 Webster St.</u>				d. STREET ADDRESS <u>45 Webster St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN WILLIAM HYDER</u>				4. DATE OF DEATH Month Day Year <u>June 8 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 27, 1907</u> 52 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician, Martins aircraft plant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>York, Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Hyder</u>				14. MOTHER'S MAIDEN NAME <u>Grace Seles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. John W. Hyder</u> Address <u>45 Webster St. Westminster, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Pancreas with Generalized Metastatic</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>over 7 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2/16/50</u> , 19 <u>50</u> , to <u>June 8, 1959</u> , that I last saw the deceased alive on <u>June 8, 1959</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Allen Moulton</u> M.D.				ADDRESS (Street, city or town, state) <u>148 W. Main St. Westminster Md.</u> DATE SIGNED <u>6/9/59</u>			
PHYSICIAN'S NAME (Type) <u>G. ALLEN MOULTON, M.D.</u>				WESTMINSTER, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 11-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Brand Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rural Westminster, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u> ADDRESS <u>Westminster, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE JUN 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Orlinda S. Hines</u>	

6603 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 Westminster</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6 Union St</u>		d. STREET ADDRESS <u>6 Union St</u>	
3. NAME OF DECEASED (Type or print) <u>SUSIE MAY JACKSON</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>?</u>
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Carroll Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Black</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Sanders</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. S. M. Barron</u>		Address <u>Union St. Westminster Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>June 5/59</u> <u>5-10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 5</u> , 19 <u>59</u> , to <u>June 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 22</u> , 19 <u>59</u> , and that death occurred at <u>1000 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. L. Speicher</u> M.D.		DATE SIGNED <u>6/23/59</u>	
PHYSICIAN'S NAME (Type) <u>W. L. Speicher</u>		ADDRESS (Street, city or town, state) <u>Westminster Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 25/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Western Chapel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rural, Westminster, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers</u>		ADDRESS <u>Westminster, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove captioned papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
6627					06618				
CERTIFICATE OF DEATH									
Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton			c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City 13x-2				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital					d. STREET ADDRESS Merriman Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hattie Middle H. Last Johnson					4. DATE OF DEATH Month June Day 19 Year 19 59				
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-5-1896		9. AGE (In years last birthday) yrs. 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lunchroom Worker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Granite, Md.			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME William Henry Lumpkins					14. MOTHER'S MAIDEN NAME Annie Johnson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. Unknown		INFORMANT Address Nannie Harrison - Sister 5935 Old Frederick Rd.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac insufficiency 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 18, 19 59 , to June 19, 19 59 that I last saw the deceased alive on June 19, 19 59 , and that death occurred at 11:30 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 6-19-59 ACTUAL SIGNATURE Edgars M. Maculans M.D. PHYSICIAN'S NAME (Type) Dr. Edgars M. Maculans, Supt. Henryton State Hospital, Henryton, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-23-59		22c. NAME OF CEMETERY OR CREMATORY Cherry Hill			22d. LOCATION (City, town, or county) (State) Granite, Md		
23. FUNERAL DIRECTOR'S SIGNATURE Edgars M. Maculans					24a. REC'D BY REGISTRAR DATE JUN 23 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kress		

CERTIFICATE OF DEATH

1937

I, John Doe, of the County of Alameda, State of California, do hereby certify that on the 15 day of April, 1937, at San Francisco, California, John Doe, of the County of Alameda, State of California, died at the residence of the decedent, John Doe, of the County of Alameda, State of California, at the age of 45 years, of Heart Disease, as shown by the medical records of the Alameda County Hospital, and as shown by the medical records of the Alameda County Hospital, and as shown by the medical records of the Alameda County Hospital.

Witness my hand and the seal of said County, at San Francisco, California, this 15 day of April, 1937.

John Doe, Registrar

My Commission Expires 15 day of April, 1938.

My Commission Expires 15 day of April, 1938.

My Commission Expires 15 day of April, 1938.

6628

CERTIFICATE OF DEATH

06619

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 1yr. 2 mo, 2days c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLARA Middle Louise Last Kellogg		4. DATE OF DEATH Month June Day 12 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 22, 1882
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 10 Days 11 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gov. Employee Clerk		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME E. Everton Kellogg		14. MOTHER'S MAIDEN NAME Mary -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or (unknown)) no		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Generalized arteriosclerosis. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis without qualifying phrase. Gangrene, right great toe.			INTERVAL BETWEEN ONSET AND DEATH years.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 15 , 19 58 , to June 12 , 19 59 , that I last saw the deceased alive on June 12 , 19 59 , and that death occurred at 12 Noon , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 6/12/59			
ACTUAL SIGNATURE Yves H. Boennec M.D.		PHYSICIAN'S NAME (Type) Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6/16/59	22c. NAME OF CEMETERY OR CREMATORY MT Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Bailey Jr.		24a. REC'D BY REGISTRAR Frederick Md.	24b. REGISTRAR'S SIGNATURE Arthur E. Hanna

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CENTRAL OFFICE OF RECORDS

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JAN 10 1954

FOR THE RECORDS SECTION

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 3yr. 5mo. 21days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frederick Middle Milliken Last Kimbel				4. DATE OF DEATH Month June Day 22 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1902		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months 57 Days 22 Hours 15 Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick layer			10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George L. Kimbel				14. MOTHER'S MAIDEN NAME Mariba Hunnell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -		INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) CBS assoc. with central nervous system syphilis, Meningoencephalitis with psychotic reaction.							INTERVAL BETWEEN ONSET AND DEATH days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with central nervous system syphilis, Meningoencephalitis with psychotic reaction.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 31, 1955 , to June 22, 1959 , that I last saw the deceased alive on June 22, 1959 , and that death occurred at 10:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 6/22/59							
ACTUAL SIGNATURE Agustin del Campo M.D.				DATE SIGNED 6/22/59			
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				SYKESVILLE, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 23		22c. NAME OF CEMETERY OR CREMATORY Green Mount Cem.		22d. LOCATION (City, town, or county) (State) Waynesburg Penna	
23. FUNERAL DIRECTOR'S SIGNATURE Elise C. Mariner ADDRESS 1970 N. Maiden St				24a. REC'D BY REGISTRAR JUN 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural--Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural--Sykesville</u>	
c. LENGTH OF STAY IN 1b <u>14yrs.</u>		d. STREET ADDRESS <u>Mineral Hill Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDGAR</u> Middle <u>J. LEATHERWOOD</u> Last		4. DATE OF DEATH Month <u>JUNE</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-16-1884</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>general</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joshua Leatherwood</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Hood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-10-0305</u>	
17. INFORMANT <u>Mrs. Mabel Leatherwood, Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 4, 1959</u> , to <u>June 21, 1959</u> , that I last saw the deceased alive on <u>June 26, 1959</u> , and that death occurred at <u>5:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. E. Martin</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>MD 6/21/59</u>	
PHYSICIAN'S NAME (Type) <u>Wm. E. Martin</u>		<u>RANDALLSTOWN Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-24-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Messiah Lutheran</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz,</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 25 '59</u>	
ADDRESS <u>Winfield, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John - Baltimore</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>7-10-38</i></p>		<p>4. DATE OF DEATH <i>1938</i></p>	
<p>5. PLACE OF DEATH <i>Home</i></p>		<p>6. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>7. MANNER OF DEATH <i>Natural</i></p>		<p>8. PLACE OF BIRTH <i>Baltimore</i></p>	
<p>9. OCCUPATION <i>None</i></p>		<p>10. MARITAL STATUS <i>Single</i></p>	
<p>11. EDUCATION <i>None</i></p>		<p>12. RELIGION <i>None</i></p>	
<p>13. SIGNATURE OF DECEASED <i>John</i></p>		<p>14. SIGNATURE OF WITNESS <i>John</i></p>	
<p>15. SIGNATURE OF DECEASED <i>John</i></p>		<p>16. SIGNATURE OF WITNESS <i>John</i></p>	
<p>17. SIGNATURE OF DECEASED <i>John</i></p>		<p>18. SIGNATURE OF WITNESS <i>John</i></p>	
<p>19. SIGNATURE OF DECEASED <i>John</i></p>		<p>20. SIGNATURE OF WITNESS <i>John</i></p>	
<p>21. SIGNATURE OF DECEASED <i>John</i></p>		<p>22. SIGNATURE OF WITNESS <i>John</i></p>	
<p>23. SIGNATURE OF DECEASED <i>John</i></p>		<p>24. SIGNATURE OF WITNESS <i>John</i></p>	
<p>25. SIGNATURE OF DECEASED <i>John</i></p>		<p>26. SIGNATURE OF WITNESS <i>John</i></p>	
<p>27. SIGNATURE OF DECEASED <i>John</i></p>		<p>28. SIGNATURE OF WITNESS <i>John</i></p>	
<p>29. SIGNATURE OF DECEASED <i>John</i></p>		<p>30. SIGNATURE OF WITNESS <i>John</i></p>	
<p>31. SIGNATURE OF DECEASED <i>John</i></p>		<p>32. SIGNATURE OF WITNESS <i>John</i></p>	
<p>33. SIGNATURE OF DECEASED <i>John</i></p>		<p>34. SIGNATURE OF WITNESS <i>John</i></p>	
<p>35. SIGNATURE OF DECEASED <i>John</i></p>		<p>36. SIGNATURE OF WITNESS <i>John</i></p>	
<p>37. SIGNATURE OF DECEASED <i>John</i></p>		<p>38. SIGNATURE OF WITNESS <i>John</i></p>	
<p>39. SIGNATURE OF DECEASED <i>John</i></p>		<p>40. SIGNATURE OF WITNESS <i>John</i></p>	
<p>41. SIGNATURE OF DECEASED <i>John</i></p>		<p>42. SIGNATURE OF WITNESS <i>John</i></p>	
<p>43. SIGNATURE OF DECEASED <i>John</i></p>		<p>44. SIGNATURE OF WITNESS <i>John</i></p>	
<p>45. SIGNATURE OF DECEASED <i>John</i></p>		<p>46. SIGNATURE OF WITNESS <i>John</i></p>	
<p>47. SIGNATURE OF DECEASED <i>John</i></p>		<p>48. SIGNATURE OF WITNESS <i>John</i></p>	
<p>49. SIGNATURE OF DECEASED <i>John</i></p>		<p>50. SIGNATURE OF WITNESS <i>John</i></p>	
<p>51. SIGNATURE OF DECEASED <i>John</i></p>		<p>52. SIGNATURE OF WITNESS <i>John</i></p>	
<p>53. SIGNATURE OF DECEASED <i>John</i></p>		<p>54. SIGNATURE OF WITNESS <i>John</i></p>	
<p>55. SIGNATURE OF DECEASED <i>John</i></p>		<p>56. SIGNATURE OF WITNESS <i>John</i></p>	
<p>57. SIGNATURE OF DECEASED <i>John</i></p>		<p>58. SIGNATURE OF WITNESS <i>John</i></p>	
<p>59. SIGNATURE OF DECEASED <i>John</i></p>		<p>60. SIGNATURE OF WITNESS <i>John</i></p>	
<p>61. SIGNATURE OF DECEASED <i>John</i></p>		<p>62. SIGNATURE OF WITNESS <i>John</i></p>	
<p>63. SIGNATURE OF DECEASED <i>John</i></p>		<p>64. SIGNATURE OF WITNESS <i>John</i></p>	
<p>65. SIGNATURE OF DECEASED <i>John</i></p>		<p>66. SIGNATURE OF WITNESS <i>John</i></p>	
<p>67. SIGNATURE OF DECEASED <i>John</i></p>		<p>68. SIGNATURE OF WITNESS <i>John</i></p>	
<p>69. SIGNATURE OF DECEASED <i>John</i></p>		<p>70. SIGNATURE OF WITNESS <i>John</i></p>	
<p>71. SIGNATURE OF DECEASED <i>John</i></p>		<p>72. SIGNATURE OF WITNESS <i>John</i></p>	
<p>73. SIGNATURE OF DECEASED <i>John</i></p>		<p>74. SIGNATURE OF WITNESS <i>John</i></p>	
<p>75. SIGNATURE OF DECEASED <i>John</i></p>		<p>76. SIGNATURE OF WITNESS <i>John</i></p>	
<p>77. SIGNATURE OF DECEASED <i>John</i></p>		<p>78. SIGNATURE OF WITNESS <i>John</i></p>	
<p>79. SIGNATURE OF DECEASED <i>John</i></p>		<p>80. SIGNATURE OF WITNESS <i>John</i></p>	
<p>81. SIGNATURE OF DECEASED <i>John</i></p>		<p>82. SIGNATURE OF WITNESS <i>John</i></p>	
<p>83. SIGNATURE OF DECEASED <i>John</i></p>		<p>84. SIGNATURE OF WITNESS <i>John</i></p>	
<p>85. SIGNATURE OF DECEASED <i>John</i></p>		<p>86. SIGNATURE OF WITNESS <i>John</i></p>	
<p>87. SIGNATURE OF DECEASED <i>John</i></p>		<p>88. SIGNATURE OF WITNESS <i>John</i></p>	
<p>89. SIGNATURE OF DECEASED <i>John</i></p>		<p>90. SIGNATURE OF WITNESS <i>John</i></p>	
<p>91. SIGNATURE OF DECEASED <i>John</i></p>		<p>92. SIGNATURE OF WITNESS <i>John</i></p>	
<p>93. SIGNATURE OF DECEASED <i>John</i></p>		<p>94. SIGNATURE OF WITNESS <i>John</i></p>	
<p>95. SIGNATURE OF DECEASED <i>John</i></p>		<p>96. SIGNATURE OF WITNESS <i>John</i></p>	
<p>97. SIGNATURE OF DECEASED <i>John</i></p>		<p>98. SIGNATURE OF WITNESS <i>John</i></p>	
<p>99. SIGNATURE OF DECEASED <i>John</i></p>		<p>100. SIGNATURE OF WITNESS <i>John</i></p>	

6631

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Airy</u>				c. LENGTH OF STAY IN 1b <u>30 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2 OAK ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1959</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec 31, 1898</u> 9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR: Months <u>60</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanics</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Garage</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Jesse Leatherwood</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Harrison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-01-5432</u> 17. INFORMANT Address <u>Mrs. Louise Leatherwood, same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute Coronary Thrombosis</u> DUE TO (b) <u>Coronary Sclerosis</u> DUE TO (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							INTERVAL BETWEEN ONSET AND DEATH <u>More than 3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>October</u> , 19 <u>55</u> , to <u>present</u> 19 _____, that I last saw the deceased alive on <u>May</u> , 19 <u>59</u> , and that death occurred at <u>7:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.B. Culwell</u> M.D. <u>900 So. Main</u> DATE SIGNED <u>6/30/59</u>				PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u> <u>Mt Airy, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7-3-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospect</u>	
22d. LOCATION (City, town, or county) <u>Frederick Co.</u> (State) <u>Md.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>C.M. Wertz</u> ADDRESS <u>Winfield, Md.</u>			
24a. REC'D BY REGISTRAR <u>JUL 6 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6632

CERTIFICATE OF DEATH

06623

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural, Westminster	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster, R.D.1 (Silver Run)		d. STREET ADDRESS Westminster, R.D.1 (Silver Run)	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Franklin H. Leppo		4. DATE OF DEATH Month June Day 3 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/17/1876
9. AGE (In years last birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	11. BIRTHPLACE (State or foreign country) Carroll Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME David K. Leppo		14. MOTHER'S MAIDEN NAME Annie Myers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-28-5607A	
17. INFORMANT Mrs. Mary C. Leppo, Westminster, Md. R.D.1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH None	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1959 , to 6-3- 1959 , that I last saw the deceased alive on 6-1- 1959 , and that death occurred at 4 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James T. Marsh		ADDRESS (Street, city or town, state) 105 E Main St Westminster Md	
DATE SIGNED 6-3-59			
PHYSICIAN'S NAME (Type) JAMES T. MARSH			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/6/59	
22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		22d. LOCATION (City, town, or county) (State) Silver Run, Carroll Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little		ADDRESS Littlestown, Pa.	
24a. REC'D BY REGISTRAR DATE JUN 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After final certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
6633 Item 9 Film G243 6-15-59 et									
CERTIFICATE OF DEATH									
Reg. Dist. No. 06624									
1. PLACE OF DEATH o. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton			c. LENGTH OF STAY IN lb 266 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			3701.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital					d. STREET ADDRESS 306 N. Eden Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Last Mack					4. DATE OF DEATH Month June Day 6, Year 19 59				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-13-05		9. AGE (In years lost birthday) yrs. 53 8/4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RIGGER		10b. KIND OF BUSINESS OR INDUSTRY Eastern Savage Co.		11. BIRTHPLACE (State or foreign country) Chester, S. C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Henry Mack					14. MOTHER'S MAIDEN NAME Bessie Fields				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 247-01-2552		INFORMANT Thomas Mack Address Patient					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Far advanced bilateral pulmonary tuberculosis DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept., 12, 19 58, to June 6, 19 59 that I last saw the deceased alive on June 6, 19 59 , and that death occurred at 2:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED ACTUAL SIGNATURE Edgars M. Maculans M.D. PHYSICIAN'S NAME (Type) Dr. Edgars M. Maculans Henryton State Hospital, Henryton, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/10/59		22c. NAME OF CEMETERY OR CREMATORY MT. CALVARY		22d. LOCATION (City, town, or county) (State) Cedar Hill, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE C. O. Wilson				ADDRESS 1000 Brawley Ave		24a. REC'D BY REGISTRAR JUN 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hous	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6634

CERTIFICATE OF DEATH

06625

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster, Md.</u>		c. LENGTH OF STAY IN 1b <u>ADULT</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sullivan Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MORRIS LEROY MARTIN</u>		4. DATE OF DEATH Month Day Year <u>JUNE 1 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 23, 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, <u>eventual retired</u>) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Martin</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Morelock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Morris M. Martin - Westminster Md RD3</u>	
17. INFORMANT <u>Morris M. Martin - Westminster Md RD3</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Coronary Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerosis (Genl)</u> (c) <u>Arterio Sclerosis (Genl)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Nov-1958</u> <u>Several yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 28</u> , to <u>June 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 23</u> , 19 <u>59</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur S. Kneer</u>		DATE SIGNED <u>6/13/59</u>	
PHYSICIAN'S NAME (Type) <u>Arthur S. Kneer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 3, 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Kredere Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rural Westminster, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers</u>		ADDRESS <u>Westminster, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUN 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneer</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6635 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06626

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Mt. Airy 13X-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) B & O R.R. at Newport Crossing				d. STREET ADDRESS Route 3			
3. NAME OF DECEASED (Type or print) First LESTER Middle LEO Last MAUCK				4. DATE OF DEATH Month June Day 21, Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-16-1917	
9. AGE (In years last birthday) 41(42)		10. IF UNDER 1 YEAR Months 4 Days 12 Hours 0 Min. 0		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanics helper				10b. KIND OF BUSINESS OR INDUSTRY garage		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME William E. Mauck				14. MOTHER'S MAIDEN NAME Mary C. Dinges			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ?		17. INFORMANT Mary C. Lizi, Mt. Airy, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of blood from lacerations of mouth and nose 810X 810X Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver in auto-train collision			
20c. TIME OF INJURY Month, Day, Year 1:00 p.m. June 21, 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Railroad tracks		20f. (City or town) (County) (State) Woodbine Carroll Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE William V. Lovitt, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-25-1959		22c. NAME OF CEMETERY OR CREMATORY Pine Grove		22d. LOCATION (City, town, or county) (State) Mt. Airy, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Walz				ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR DATE JUN 25 '59	
						24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

6636
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Miller</i>	c. LENGTH OF STAY IN 1b <i>20 yrs.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Miller</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>LEE - A - MCGEE</i>		4. DATE OF DEATH <i>June 16 1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 12 - 1872</i>
9. AGE (In years last birthday) <i>87</i> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Railroad Employee</i>	11. BIRTHPLACE (State or foreign country) <i>MD</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		13. FATHER'S NAME <i>William McGee</i>	
14. MOTHER'S MAIDEN NAME <i>Sarah Henry</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>✓</i>		17. INFORMANT <i>Mrs Earl Hawn Miller MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> <i>4200</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>April 1958</i> , to <i>June 16 1959</i> , that I last saw the deceased alive on <i>6/5</i> , 1959, and that death occurred at <i>11:20 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W.H. Foard</i>		DATE SIGNED <i>6/16/59</i>	
PHYSICIAN'S NAME (Type) <i>W.H. Foard M.D.</i>		<i>Manchester, MD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>6-18-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Seaton's Church</i>	22d. LOCATION (City, town, or county) (State) <i>Carroll Co MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edw. Chpton</i>		24a. REC'D BY REGISTRAR <i>JUN 18 '59</i>	
ADDRESS <i>Hampstead MD</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

40053

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

CERTIFICATE OF DEATH

1934

W. E. M. B. M. D.

1

Name of Deceased		Sex		Age	
Date of Birth		Place of Birth		Usual Residence	
Cause of Death		Duration of Illness		Time of Death	
Place of Death		Occupation		Marital Status	
Signature of Physician		Signature of Registrar		Signature of Informant	
Date of Death		Date of Registration		Date of Filing	
County		City		State	

6637

CERTIFICATE OF DEATH

06628

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 8yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES H. MILTER		4. DATE OF DEATH Month June Day 16 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-26-1882
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer-retired		10b. KIND OF BUSINESS OR INDUSTRY own	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Charles Herman Milter		14. MOTHER'S MAIDEN NAME Catherine Bursch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Claude Haines,		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Arteriosclerotic heart disease, Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Hypertension, Cerebral hemorrhage (c) Cardiac failure			INTERVAL BETWEEN ONSET AND DEATH 15 June 59 to 16 June 59
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 19 55 , 19 55 , to 16 June 59 , that I last saw the deceased alive on 16 June 59 , and that death occurred at 11:20 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Howard E. Hall		DATE SIGNED 16 June 59	
PHYSICIAN'S NAME (Type) HOWARD E. HALL		ADDRESS (Street, city or town, state) Sykesville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6-19-1959	22c. NAME OF CEMETERY OR CREMATORY Morgan Chapel	22d. LOCATION (City, town, or county) (State) Carroll Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.	
24a. REC'D BY REGISTRAR DATE JUN 19 '59		24b. REGISTRAR'S SIGNATURE Arthur J. Haines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

28300

CERTIFICATE OF DEATH

2832

1

6638 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN lb 1,940 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis 0210-2		d. STREET ADDRESS 110 O'Berry Court	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Naomi Middle Esther Last Offer		4. DATE OF DEATH Month June Day 26 Year 19 59	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov., 25, 1937
9. AGE (In years last birthday) 21 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework-Child care		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Eugene Offer		14. MOTHER'S MAIDEN NAME Annie Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address Annapolis, Md.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Far advanced bilateral pulmonary cavitary Tbc. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 years		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 4, 19 54 , to June 26, 19 59 , that I last saw the deceased alive on June 26, 19 59 , and that death occurred at 3:30A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. E. M. Maculans M.D.		DATE SIGNED Henryton, Maryland	
PHYSICIAN'S NAME (Type) Dr. Edgars M. Maculans, Supt.		Henryton State Hospital, Henryton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 6-29-59	22c. NAME OF CEMETERY OR CREMATORY Brewer Hill	22d. LOCATION (City, town, or county) (State) Annapolis, Md.
23. FUNERAL DIRECTOR'S SIGNATURE William Reese ADDRESS Baltimore, Md.		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE Arthur S. Kline
DATE JUL 1 '59			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES DEPARTMENT OF HEALTH

1933

General
Hospital
The following names are listed
in the order of their admission
to the hospital
Name
Age
Sex
Date of Admission
Date of Discharge
Diagnosis
Treatment
Remarks

1. John Doe, 45, Male, 1933, 1934, Pneumonia, 10 days, Recovered.
2. Jane Smith, 32, Female, 1933, 1934, Tuberculosis, 12 months, Recovered.
3. Robert Johnson, 58, Male, 1933, 1934, Heart Disease, 6 months, Recovered.
4. Mary White, 28, Female, 1933, 1934, Diabetes, 3 months, Recovered.
5. William Brown, 65, Male, 1933, 1934, Cancer, 18 months, Deceased.
6. Elizabeth Green, 40, Female, 1933, 1934, Asthma, 1 year, Recovered.
7. Charles Black, 35, Male, 1933, 1934, Hypertension, 9 months, Recovered.
8. Margaret Gray, 25, Female, 1933, 1934, Depression, 6 months, Recovered.
9. Thomas White, 70, Male, 1933, 1934, Alzheimer's, 1 year, Deceased.
10. Susan Black, 30, Female, 1933, 1934, Schizophrenia, 12 months, Recovered.

6639 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 15yrs. 27days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 524 N. Belnord Ave.	
3. NAME OF DECEASED (Type or print) First William Middle David Last Otto		4. DATE OF DEATH Month June Day 1 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1918
9. AGE (In years last birthday) 41		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer's helper		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME E. L. Otto		14. MOTHER'S MAIDEN NAME Rosa Senger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 491X DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with convulsive disorder, epileptic deterioration.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 20, 1954 to June 1, 1959 , that I last saw the deceased alive on May 31, 1959 , and that death occurred at 5:10A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 6/1/59 ACTUAL SIGNATURE Edmund Lusthaus M.D. Springfield State Hospital PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-4-59	22c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.	22d. LOCATION (City, town, or county) (State) Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE John C. Mellow Inc. - 2431 E. Olive St.		24a. REC'D BY REGISTRAR DATE JUN 3 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hearn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100331

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

6-4-59

Page One of One

1. NAME OF DECEASED JAMES H. BROWN		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1900		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Retired		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1925		9. PLACE OF MARRIAGE Baltimore, Md.		10. NAME OF SPouse Mary H. Brown	
11. DATE OF DEATH June 4, 1959		12. PLACE OF DEATH Home		13. CAUSE OF DEATH Heart Disease		14. MANNER OF DEATH Natural		15. SIGNATURE OF PHYSICIAN J. H. Smith	
16. SIGNATURE OF DECEASED JAMES H. BROWN		17. SIGNATURE OF WITNESS Mary H. Brown		18. SIGNATURE OF PHYSICIAN J. H. Smith		19. SIGNATURE OF REGISTRAR J. H. Smith		20. SIGNATURE OF CLERK J. H. Smith	
21. NAME OF HOSPITAL None		22. NAME OF NURSING HOME None		23. NAME OF HOME None		24. NAME OF PLACE None		25. NAME OF PLACE None	
26. NAME OF PLACE None		27. NAME OF PLACE None		28. NAME OF PLACE None		29. NAME OF PLACE None		30. NAME OF PLACE None	
31. NAME OF PLACE None		32. NAME OF PLACE None		33. NAME OF PLACE None		34. NAME OF PLACE None		35. NAME OF PLACE None	
36. NAME OF PLACE None		37. NAME OF PLACE None		38. NAME OF PLACE None		39. NAME OF PLACE None		40. NAME OF PLACE None	
41. NAME OF PLACE None		42. NAME OF PLACE None		43. NAME OF PLACE None		44. NAME OF PLACE None		45. NAME OF PLACE None	
46. NAME OF PLACE None		47. NAME OF PLACE None		48. NAME OF PLACE None		49. NAME OF PLACE None		50. NAME OF PLACE None	
51. NAME OF PLACE None		52. NAME OF PLACE None		53. NAME OF PLACE None		54. NAME OF PLACE None		55. NAME OF PLACE None	
56. NAME OF PLACE None		57. NAME OF PLACE None		58. NAME OF PLACE None		59. NAME OF PLACE None		60. NAME OF PLACE None	
61. NAME OF PLACE None		62. NAME OF PLACE None		63. NAME OF PLACE None		64. NAME OF PLACE None		65. NAME OF PLACE None	
66. NAME OF PLACE None		67. NAME OF PLACE None		68. NAME OF PLACE None		69. NAME OF PLACE None		70. NAME OF PLACE None	
71. NAME OF PLACE None		72. NAME OF PLACE None		73. NAME OF PLACE None		74. NAME OF PLACE None		75. NAME OF PLACE None	
76. NAME OF PLACE None		77. NAME OF PLACE None		78. NAME OF PLACE None		79. NAME OF PLACE None		80. NAME OF PLACE None	
81. NAME OF PLACE None		82. NAME OF PLACE None		83. NAME OF PLACE None		84. NAME OF PLACE None		85. NAME OF PLACE None	
86. NAME OF PLACE None		87. NAME OF PLACE None		88. NAME OF PLACE None		89. NAME OF PLACE None		90. NAME OF PLACE None	
91. NAME OF PLACE None		92. NAME OF PLACE None		93. NAME OF PLACE None		94. NAME OF PLACE None		95. NAME OF PLACE None	
96. NAME OF PLACE None		97. NAME OF PLACE None		98. NAME OF PLACE None		99. NAME OF PLACE None		100. NAME OF PLACE None	

CERTIFICATE OF DEATH

Reg. Dist. No.

6640

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 44yrs. 10mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS Baltimore, Md.	
3. NAME OF DECEASED (Type or print) First Emma Middle PAUL Last PAUL		4. DATE OF DEATH Month June Day 18, Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1882
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min.	11. IF UNDER 24 HRS. Months 77 Days 77 Hours 77 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salvation Army Worker		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene of foot 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerotic heart disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes. Schizophrenic reaction, hebephrenic type.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Days Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August , 19 39 , to June 18, 19 59 , that I last saw the deceased alive on June 18, 19 59 , and that death occurred at 9:25 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ellis S. Margolin		ADDRESS (Street, city or town, state) Springfield Hospital	
PHYSICIAN'S NAME (Type) Ellis S. Margolin, M.D.		DATE SIGNED 6/19/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) 6/22-59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY W. of Md. Med School		22d. LOCATION (City or town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		24. REC'D BY REGISTRAR JUN 25 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Carroll & Sons	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1988

CERTIFICATE OF DEATH

1988

1988

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Date of birth: [illegible]
4. Date of death: [illegible]
5. Place of death: [illegible]
6. Cause of death: [illegible]
7. Signature of physician: [illegible]
8. Signature of registrar: [illegible]
9. Date of registration: [illegible]

CERTIFICATE OF DEATH

1964

Carroll

22

1964

County of Lincoln

William

1964

ACTING CLERK

1964-1965

Signature of the Clerk

Signature of the Judge

Witnesses

Signature of the Clerk

Signature of the Judge

1964-1965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6642

CERTIFICATE OF DEATH

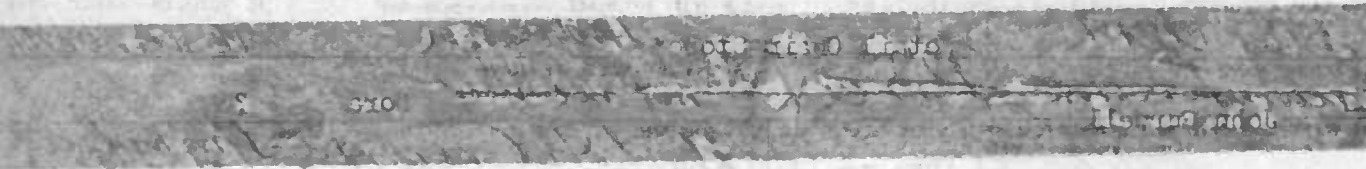
06633

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville, Md</i>		c. LENGTH OF STAY IN <i>2 yrs 5 months</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Springfield State Hospital</i>		d. STREET ADDRESS <i>5408 Grinnell Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Gentle Mae Price</i>		4. DATE OF DEATH <i>June 21 1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-21-88</i>
9. AGE (In years last birthday) <i>70</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sales Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retail Chain Store</i>	
11. BIRTHPLACE (State or foreign country) <i>Indiana</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A. birth</i>	
13. FATHER'S NAME <i>John Carroll</i>		14. MOTHER'S MAIDEN NAME <i>Nora</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Yes</i>	
17. INFORMANT <i>Hospital records, Springfield Hosp</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> 422.2 DUE TO <i>Chronic degenerative Myocarditis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Old right side Hemiplegia</i> DUE TO (c) <i>Chronic brain syndrome with cerebral Arteriosclerosis & psychotic reaction</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic brain syndrome with cerebral Arteriosclerosis & psychotic reaction</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov. 18</i> , 19 <i>58</i> , to <i>June 20</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>June 20</i> , 19 <i>59</i> , and that death occurred at <i>2:24 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Konstantin Weber</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>KONSTANTIN WEBER</i>		<i>SYKESVILLE, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		22b. DATE THEREOF <i>June 21, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Riverview Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Seymour Indiana</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Tickner & Sons</i>		ADDRESS <i>Balto, Md.</i>	
24a. REC'D BY REGISTRAR <i>DATE JUN 22 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

CERTIFICATE OF DEATH

PLACE OF DEATH		DEATH	
DATE OF DEATH		TIME OF DEATH	
AGE		SEX	
MARRIED		OCCUPATION	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		TIME	



PLACE OF DEATH		DEATH	
DATE OF DEATH		TIME OF DEATH	
AGE		SEX	
MARRIED		OCCUPATION	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		TIME	

6643

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS R. 4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Rittenhouse Last Pugh				4. DATE OF DEATH Month June Day 12 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1900		9. AGE (In years last birthday) yrs. 58	IF UNDER 1 YEAR Months 12 Days 19 Hours 59	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Engineer		10b. KIND OF BUSINESS OR INDUSTRY Leas. R. R.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME William Morrow Pugh				14. MOTHER'S MAIDEN NAME Eleanor Agnes Myers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 717-07-8691		INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Urinary infection DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychotic depressive reaction.							INTERVAL BETWEEN ONSET AND DEATH days weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1 , 19 59 , to June 12 , 19 59 , that I last saw the deceased alive on June 11 , 19 59 , and that death occurred at 6:00AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 6/12/59 ACTUAL SIGNATURE Agustin del Campo M.D. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-14-59		22c. NAME OF CEMETERY OR CREMATORY Freedom		22d. LOCATION (City, town, or county) (State) Elkridge, Carroll Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Luther A. Haight Sykesville, Md.				24a. REC'D BY REGISTRAR DATE JUN 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County of _____

City and Town of _____

Date of Death _____

Decedent's Name _____

Age _____

Sex _____

Married _____

Single _____

Time _____

Place _____

Occupation _____

Cause _____

Time _____

Place _____

Time _____

Place _____

Time _____

Place _____

Time _____

Time _____

Time _____

Time _____

Time _____

Time _____

Time _____

Time _____

Time _____

Time _____

Time _____

Time _____

Time _____

Time _____

Time _____

Time _____

Time _____

Time _____

6644

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 26y 5 m 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Blanche Middle V. Last Rider				4. DATE OF DEATH Month 6 Day 28 Year 1959			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, Sept. 1892	9. AGE (In years last birthday) yrs. 66	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel keeper				10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.,				13. FATHER'S NAME William A. Mc Conas			
14. MOTHER'S MAIDEN NAME Alice V. Stenger				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. none unkn				INFORMANT Address S.S. Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, unresolved DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with mental deficiency, Chronic Cholelithiasis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Springfield State Hospital	(County)	(State)		
21. I certify that I attended the deceased from 10-20-- , 19 54 , to 6-28-- , 19 59 , that I lost saw the deceased alive on 6-28-- , 19 59 , and that death occurred on 10:30A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus		ADDRESS (Street, city or town, state) Springfield State Hospital			DATE SIGNED 6-28-59		
PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.		Sykesville, Maryland.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 30, 1959	22c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial	22d. LOCATION (City, town, or county) Abingdon, Harford, Md.,	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE A. K. Mc Conas		ADDRESS Abingdon, Md.		24a. REC'D BY REGISTRAR JUL 1 '59	24b. REGISTRAR'S SIGNATURE Charles E. Evans		

CERTIFICATE OF DEATH

County

State

City

Dec. 1 in 11 days

Age

Married

Place

Sex

Color

Birth

Place

State

City

Dec. 1, 1900

None

None

None

None

Remains with family, buried in cemetery

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

6645

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Carroll</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Sykesville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Sykesville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Walter James Ross</i>				4. DATE OF DEATH Month Day Year <i>June 26 1959</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 4, 1899</i>	9. AGE (In years last birthday) <i>60</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Electrical</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Truman O. Ross</i>				14. MOTHER'S MAIDEN NAME <i>Ellen Adams</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>[If yes, give war or dates of service]</i>		16. SOCIAL SECURITY NO. <i>218-05-0067</i>		17. INFORMANT Address <i>Mrs. Elsie Ross - Sykesville, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> 287X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cor pulmonale</i> DUE TO (c) <i>obesity and hypertension</i>						INTERVAL BETWEEN ONSET AND DEATH <i>few minutes</i> <i>4 weeks</i> <i>15 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6-9-59</i> , 1959, to <i>6-9-26</i> , 1959, that I last saw the deceased alive on <i>6-25</i> , 1959, and that death occurred at <i>9:35 P.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Bertrand R. Gall</i>				ADDRESS (Street, city or town, state) <i>37 Central Ave. Sykesville, Md.</i>		DATE SIGNED <i>6-27-59</i>	
PHYSICIAN'S NAME (Type) <i>Bertrand R. Gall</i>				<i>SYKESVILLE Maryland</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-30-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Springfield</i>		22d. LOCATION (City, town, or county) (State) <i>Sykesville, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Arthur H. Haight Sykesville, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>JUN 30 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1965

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

10038

DATE OF DEATH

PLACE OF DEATH

HASTINGS

CITY OR TOWN IN WHICH DEATH OCCURRED

COUNTY IN WHICH DEATH OCCURRED

STATE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CITY OR TOWN IN WHICH DEATH OCCURRED

COUNTY IN WHICH DEATH OCCURRED

STATE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CITY OR TOWN IN WHICH DEATH OCCURRED

COUNTY IN WHICH DEATH OCCURRED

STATE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CITY OR TOWN IN WHICH DEATH OCCURRED

COUNTY IN WHICH DEATH OCCURRED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6646 CERTIFICATE OF DEATH

06637

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u>		d. STREET ADDRESS <u>RURAL</u>	
3. NAME OF DECEASED (Type or print) <u>DEANIE VIRGINIA ROYER</u>		4. DATE OF DEATH <u>JUNE 1 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-JUNE 1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>JOSEPH WOODS</u>	
14. MOTHER'S MAIDEN NAME <u>LAURA GRASS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>213-01-9972</u>		17. INFORMANT <u>MRS. M.E. TRITE, NEW WINDSOR, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>5/1/59</u> , 19, to <u>6/1/59</u> , 19, that I last saw the deceased alive on <u>5/31/59</u> , 19, and that death occurred at <u>12:05</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. E. Robertson</u>		ADDRESS (Street, city or town, state) <u>New Windsor, Md.</u> DATE SIGNED <u>6/1/59</u>	
PHYSICIAN'S NAME (Type) <u>M. E. ROBERTSON</u>		<u>NEW WINDSOR MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/3/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MEADOW BRANCH CEM.</u>	22d. LOCATION (City, town, or county) <u>WESTMINSTER MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartman</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
ADDRESS <u>New Windsor Md</u>		DATE <u>JUN 3 '59</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completed by the funeral director. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06638

6647 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Grand View Nursing Home				d. STREET ADDRESS 4405 Linkwood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary		First V.		Last Schwarzkopf		4. DATE OF DEATH Month June Day 21, Year 19 59	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 4, 1874		9. AGE (In years last birthday) 85 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Robert Perry				14. MOTHER'S MAIDEN NAME Artridge Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Elizabeth B. Brooks		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 XXXX ARTERIOSCLEROTIC HEART DISEASE WITH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) SENILE CHANGES INTERVAL BETWEEN ONSET AND DEATH not known							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 24, 1958, to June 21, 1959, that I last saw the deceased alive on June 21, 1959, and that death occurred at 2:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Sykesville, Maryland 6/21/59 ACTUAL SIGNATURE M.D. Wm. H. Lawson, Jr., M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-24-59		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. W. Jenkins & Sons Co. In. Balto., Md.				24a. REC'D BY REGISTRAR DATE JUN 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 2. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6648

CERTIFICATE OF DEATH

Reg. Dist. No.

07801

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oakland Mills, Maryland</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <i>Spryfield State Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Rachel</i> First <i>A. SELLMAN</i> Middle <i>S</i> Last <i>SELLMAN</i>				4. DATE OF DEATH <i>June 28 1959</i> Month <i>June</i> Day <i>28</i> Year <i>1959</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1870</i>	9. AGE (In years last birthday) <i>88</i>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H. W.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A. Born</i>	
13. FATHER'S NAME <i>Edward Decraft</i>				14. MOTHER'S MAIDEN NAME <i>Mary Porter</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Hospital Records</i> Address			
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho-pneumonia</i> <i>422.1</i> DUE TO <i>Bronchial Asthma</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>arteriosclerotic Cardiovascular System</i> DUE TO (b) <i>arteriosclerotic Cardiovascular System</i> (c) <i>Psychosis with Mental Deficiency</i>							INTERVAL BETWEEN ONSET AND DEATH <i>Days</i> <i>Years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	Month <i>Nov</i>	Day <i>18</i>	Year <i>1958</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Oak Street</i>	20f. (City or town) <i>Sykesville, Md</i>	(County) <i>Carroll</i> (State) <i>Md</i>
21. I certify that I attended the deceased from <i>Nov 18 1958</i> to <i>June 28 1959</i> that I last saw the deceased alive on <i>June 28 1959</i> and that death occurred at <i>12:30 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Konstantin Weber</i> M.D.				DATE SIGNED <i>June 28 1959</i>			
PHYSICIAN'S NAME (Type) <i>KONSTANTIN WEBER M.D.</i>				ADDRESS (Street, city or town, state) <i>Sykesville, Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-9-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Freedom</i>		22d. LOCATION (City, town, or county) <i>Calderburg, Carroll, Md.</i> (State) <i>Md</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ruth H. Haight</i> ADDRESS <i>Sykesville, Md</i>				24a. REC'D BY REGISTRAR <i>Jul 13 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6649

CERTIFICATE OF DEATH

06639

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb 2 m 13 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Md. d. STREET ADDRESS 205 S. Manor Circle e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rosella Middle Dellila Last Shoup		4. DATE OF DEATH Month 6 Day 14 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 - 15 - 66
9. AGE (In years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months 14 Days 19 Hours 59	11. IF UNDER 24 HRS. Months 14 Days 19 Hours 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ohio	11. BIRTHPLACE (State or foreign country) U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Platz	
14. MOTHER'S MAIDEN NAME Elizabeth Gordon		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. S.S. Hospital Records		17. ADDRESS S.S. Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Agranulocytosis due to drug reaction 297x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease, with psych. reaction. Positive blood serology			
INTERVAL BETWEEN ONSET AND DEATH weeks			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 4-1- 19 59 , to 6-14- 19 59 , that I last saw the deceased alive on 6-14- 19 59 , and that death occurred at 3:05 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Edmund Lusthaus M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 6-14-59	
PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.		SYKESVILLE, MARYLAND.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 16, 1959	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters, 254 Carroll St NW		24a. REC'D BY REGISTRAR JUN 16 '59 24b. REGISTRAR'S SIGNATURE Arthur E. Hines	

6650

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Windsor</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Windsor</u>			
c. LENGTH OF STAY IN 1b <u>11 yrs.</u>				d. STREET ADDRESS <u>324 College Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>324 College Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET JANE SMELSER</u>				4. DATE OF DEATH Month Day Year <u>JUNE 30 1959</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 3, 1872</u>		9. AGE (In years last birthday) <u>87</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Solomon Brothers</u>				14. MOTHER'S MAIDEN NAME <u>Ella Fowler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Jas. A. Danner, New Windsor Md.</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral softening</u> <u>332x</u> DUE TO <u>Arteriosclerosis</u> (b) <u>"little strokes"</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos 4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 1957</u> , to <u>June 30, 1959</u> , that I last saw the deceased alive on <u>June 2, 1959</u> , and that death occurred at <u>9 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>15 Kenner Ave, Westminster, Md.</u> DATE SIGNED <u>June 29, 1959</u>							
ACTUAL SIGNATURE <u>E. Reese Wilkens</u>				PHYSICIAN'S NAME (Type) <u>Dr. E. Reese Wilkens</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 2 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverside Cemetery, Rural, Westminster, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers Jr. Westminster, Md.</u> ADDRESS <u>—</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JUL 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Orlino L. Kane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6651

CERTIFICATE OF DEATH

06641

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cassell</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Franklin Rural</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Polotsco Rd</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Leslie Vernon Spencer</u>		4. DATE OF DEATH <u>June 12 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 30. 1888</u> 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer-Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mayland</u>	
11. BIRTHPLACE (State or foreign country) <u>Ms.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles W. Spencer</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Snyder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-12-2805</u>	
17. INFORMANT <u>Rhoda Baltimore</u>		Address <u>Franklin Ind</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cerebral Accidents</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Suddenly</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Apr 24</u> , 19 <u>53</u> , to <u>June 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 20</u> , 19 <u>59</u> , and that death occurred at <u>8:17 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>6/12/59</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D.</u>		<u>HAMPSTEAD Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 15, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Patapsco Cemetery</u>		22d. LOCATION (City, town, or county) <u>Patapsco, Maryland</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Byers</u> ADDRESS <u>Westminster, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 16 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6652

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X HAMPSTEAD Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRMOUNT Rd.</u>		d. STREET ADDRESS <u>FAIRMOUNT Rd</u>	
3. NAME OF DECEASED (Type or print) <u>BETTIE Victoria</u> First Middle Last		4. DATE OF DEATH <u>June 30 1959</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 12, 1873</u> 9. AGE (In years last birthday) <u>86</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JERRY Stansbury</u>		14. MOTHER'S MAIDEN NAME <u>SARAH ZIMMERMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Chester STAGNER</u> Address <u>HAMPSTEAD, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per the far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO <u>Arteriosclerotic Cardio-Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>JUNE 24, 1959</u> to <u>JUNE 30, 1959</u> , that I last saw the deceased alive on <u>JUNE 29, 1959</u> , and that death occurred at <u>3:20 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Maryland</u> DATE SIGNED <u>6/30/59</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush, M.D.</u>		<u>HAMPSTEAD Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-2-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hampstead</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin E. Lipton</u> ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>JUL 2 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06643

6604

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 Westminster</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>83 W. Main St.</u>				d. STREET ADDRESS <u>1 83 W Main St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>RUTH NAOMI STARNER</u>				4. DATE OF DEATH Month Day Year <u>June 27 1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 21 1908</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Jacob J. Frock</u>				14. MOTHER'S MAIDEN NAME <u>Jamie Myers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT <u>Mr C. David Starnor, Westminster Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension, nephritis 1945</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 4 1959</u> , to <u>June 27 1959</u> , that I last saw the deceased alive on <u>June 27 1959</u> , and that death occurred at <u>4508 M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>103 E Main Westminster Md</u> DATE SIGNED <u>6-29-59</u> ACTUAL SIGNATURE <u>Wm C. Jennette</u> M.D. <u>103 E Main Westminster Md</u> PHYSICIAN'S NAME (Type) <u>Wm C. Jennette</u> <u>103 E Main Westminster Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 30 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Valley Cemetery Rural Westminster Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. Myers, Jr. Westminster Md</u> ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
				DATE <u>JUL 1 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6653

CERTIFICATE OF DEATH

06644

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Maryland c. LENGTH OF STAY IN 1b lmo. 12 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 717 Glenwood Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Augusta Henrietta Tarr			4. DATE OF DEATH Month Day Year June 26 19 59		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1873	9. AGE (In years last birthday) yrs. 86	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Walter Tarr			14. MOTHER'S MAIDEN NAME ---		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. ---		
17. INFORMANT Springfield Hospital Records			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with cerebral arteriosclerosis, with psychotic reaction.					INTERVAL BETWEEN ONSET AND DEATH Years Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from May 14 , 19 59 , to June 26 , 19 59 that I last saw the deceased alive on June 26 , 19 59 , and that death occurred at 11:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 6/26/59 ACTUAL SIGNATURE Agustin del Campo M.D. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. Sykesville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-29-1959		22c. NAME OF CEMETERY OR CREMATORY Louder Park	
22d. LOCATION (City, town, or county) (State) Baltimore					
23. FUNERAL DIRECTOR'S SIGNATURE Sentry Funeral Home			24a. REC'D BY REGISTRAR DATE JUN 30 '59		
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna					

1

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
EDUCATION: [illegible]
OCCUPATION: [illegible]
RELIGION: [illegible]
MARRIAGE: [illegible]
PREVIOUS ILLNESSES: [illegible]
PRESENT ILLNESS: [illegible]
DATE OF ONSET: [illegible]
DATE OF EXAMINATION: [illegible]
EXAMINER: [illegible]

PHYSICAL EXAMINATION: [illegible]
VITAL SIGNS: [illegible]
LABORATORY TESTS: [illegible]
X-RAY: [illegible]
DIAGNOSIS: [illegible]
TREATMENT: [illegible]
PROGNOSIS: [illegible]
FOLLOW-UP: [illegible]

DATE OF DISCHARGE: [illegible]
PLACE OF DISCHARGE: [illegible]
NAME OF PHYSICIAN: [illegible]
NAME OF HOSPITAL: [illegible]
ADDRESS: [illegible]
CITY: [illegible]
STATE: [illegible]
ZIP: [illegible]
TELEPHONE: [illegible]
FAX: [illegible]
E-MAIL: [illegible]

6654

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg 15x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 302 N. Frederick Ave.	
3. NAME OF DECEASED (Type or print) First Thomas Middle Theador Last Utterback		4. DATE OF DEATH Month June Day 25 , Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1882
9. AGE (In years last birthday) yrs. 77		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Utterback		14. MOTHER'S MAIDEN NAME Mary Elizabeth Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -	
INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain disease with psychotic reaction.			INTERVAL BETWEEN ONSET AND DEATH Instant Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 22, 19 57, to June 25, 19 59, that I last saw the deceased alive on June 24, 19 59, and that death occurred at 12:15AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Agustin del Campo</i>		ADDRESS (Street, city or town, state) DATE SIGNED Springfield Hospital 6/25/59	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-28-59	22c. NAME OF CEMETERY OR CREMATORY Brown's Chapel Cemetery	22d. LOCATION (City, town, or county) (State) Fairfax, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE <i>Forrest A. Sanders</i>		24a. REC'D BY REGISTRAR 30 59	
ADDRESS <i>Gaithersburg</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	

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Page 4

death. Pages 1 and 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH



Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to blurriness and bleed-through from the reverse side.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6655 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06646

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural--Westminster</u>		c. LENGTH OF STAY IN 1b <u>7 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural--Westminster</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS <u>Bear Branch Road</u>		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>MARGARET CATHERINE WALKER</u>			4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>1959</u>		
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>7-8-1893</u>		9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>Jacob Dunn</u>			14. MOTHER'S MAIDEN NAME <u>unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Mr. Albert G. Walker, same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>A.S.C.V disease & hypertension</u> (a), stating the underlying cause last. DUE TO (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James J. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6/14/59</u>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-17-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Taylorville</u>	
22d. LOCATION (City, town, or county) <u>Carroll Co., Md.</u>		22e. (State) <u> </u>		22f. (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz,</u>		ADDRESS <u>Winfield, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 17 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		24c. (State) <u> </u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00820

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
JAMES J. JONES		M		45		JAN 15 1945	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1234 E. MAIN ST.		LABORER		HEART DISEASE		NATURAL	
CITY		COUNTY		STATE		FEDERAL DISTRICT	
BALTIMORE		BALTIMORE		MARYLAND		DISTRICT OF COLUMBIA	
SIGNED		DATE		PLACE		BY	
J. J. JONES		JAN 15 1945		BALTIMORE		J. J. JONES	
MEDICAL EXAMINER		DECEASED'S SIGNATURE		DECEASED'S ADDRESS		DECEASED'S CITY	
J. J. JONES		J. J. JONES		1234 E. MAIN ST.		BALTIMORE	
DECEASED'S CITY		DECEASED'S STATE		DECEASED'S COUNTY		DECEASED'S DISTRICT	
BALTIMORE		MARYLAND		BALTIMORE		DISTRICT OF COLUMBIA	
DECEASED'S OCCUPATION		DECEASED'S RESIDENCE		DECEASED'S DATE OF BIRTH		DECEASED'S SEX	
LABORER		1234 E. MAIN ST.		JAN 15 1945		M	
DECEASED'S CITY		DECEASED'S STATE		DECEASED'S COUNTY		DECEASED'S DISTRICT	
BALTIMORE		MARYLAND		BALTIMORE		DISTRICT OF COLUMBIA	
DECEASED'S OCCUPATION		DECEASED'S RESIDENCE		DECEASED'S DATE OF BIRTH		DECEASED'S SEX	
LABORER		1234 E. MAIN ST.		JAN 15 1945		M	
DECEASED'S CITY		DECEASED'S STATE		DECEASED'S COUNTY		DECEASED'S DISTRICT	
BALTIMORE		MARYLAND		BALTIMORE		DISTRICT OF COLUMBIA	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6656

CERTIFICATE OF DEATH

06647

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster		c. LENGTH OF STAY IN 1b 1 Year	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster, Md. R. D. 1	
d. STREET ADDRESS Westminster, Md. R. D. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Franklin Last Watson		4. DATE OF DEATH Month June Day 24 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6/1900
9. AGE (In years last birthday) 59		IF UNDER 1 YEAR Months 5 Days 20 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Foundry Employee		10b. KIND OF BUSINESS OR INDUSTRY Foundry	
11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Watson		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 185-03-1665	
17. INFORMANT Shreet Address (Westminster) Mrs. Rosa Blanch-Shreet Westminster, Md. R. D. 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor pulmonale 523.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Silicosis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 5 years 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 2, 1957 to June 24, 1959 , that I last saw the deceased alive on June 23, 1959 , and that death occurred at 1:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Seah Maitland		ADDRESS (Street, city or town, state) Littlestown, Pa.	
PHYSICIAN'S NAME (Type) LEAH MAITLAND, M.D.		DATE SIGNED 6/24/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/27/59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Littlestown, Adams Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little		24a. REC'D BY REGISTRAR DATE JUL 1 '59	
ADDRESS Littlestown, Pa.		24b. REGISTRAR'S SIGNATURE Richard S. Frank	

6657

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>H.A.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SYKESVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HUMPHRIES</u> 0210.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Palmer Nursing Home</u>		d. STREET ADDRESS <u>PRINCE GEORGE ST.</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM C. WERNITZ</u>		4. DATE OF DEATH <u>JUNE 24</u> 19 <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 6-1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Instructor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private School</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Edward Wernitz</u>		14. MOTHER'S MAIDEN NAME <u>Emma M. Bedford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Elsie Garner Wernitz</u>	
17. INFORMANT <u>Elsie Garner Wernitz</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure, bronchial pneumonia</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral hemorrhage, at Humphries</u> DUE TO (c) <u>Arteriosclerosis generalized</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>20 June</u> 19 <u>59</u> , to <u>24 June</u> 19 <u>59</u> , that I last saw the deceased alive on <u>24 June</u> 19 <u>59</u> , and that death occurred at <u>3:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u>		ADDRESS (Street, city or town, state) <u>Sykesville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		DATE SIGNED <u>4 June 59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>6-26-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>	22d. LOCATION (City, town, or county) (State) <u>HUMPHRIES MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>		ADDRESS <u>Cincinnati, Ohio</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician, after the death certificate has been signed by the attending physician and completed, may file it with the funeral director. After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

